YOUTH ENROLLMENT

Please fill out ALL information! **Please PRINT!**

Name of Member: **(Last, First, MI)**	
MEMBER ID NUMBER ***Must pick a number of at least 6 digits for check-in**	**6 required – 7th optional NUMBERS ONLY** ___ ___ ___ ___ ___ ___ ___
	Sex: _____ Age: _____ Date of Birth: _______________
Home Address, City, Zip:	______________________________ ______________________________
Home Phone:	
Cell Phone:	
Email:	
Parent(s) Name:	
Parent(s) Work Phone:	

PLEASE RESPOND TO THE FOLLOWING QUESTIONS:

	YES	NO
1. Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?		
2 Do you feel pain in your chest when you do physical activity?		
3. In the past month, have you had chest pain when you were not doing physical activity?		
4. Do you lose your balance because of dizziness or do you ever lose consciousness?		
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heat condition?		
7. Do you know of any other reason why you should not do physical activity?		

WAIVER AND RELEASE:

I desire to voluntarily participate in Ohio University's Well Works program. I understand that during my fitness assessment and in participation of Well Works activities, that certain dangers exist, such as fainting, abnormal blood pressures, dizziness, and in very rare instances, heart attacks. More common injuries include soft tissue injuries--e.g. sore muscles, tendinitis. Every effort will be made to minimize these conditions through the preliminary examination and by observations during admission. Should there be any reason to question my health or ability to safely participate in Well Works, I assume full responsibility in obtaining the advice of my physician.

In consideration of my entry into this program, I, my heirs, executor, administrators, and assigns do hereby release and discharge Ohio University, its officers, agents, sponsors, or employees from any responsibility or liability for any subsequent exercise or other activities that I may engage in as the result of attending this program. I understand that any abnormal results will be sent to the following named physician, _________________________, for appropriate follow-up. I attest that I have full knowledge of any and all risks involved in participating in the Well Works program. I further give permission for Ohio University to use data collected during the program. I understand these data will only be repeated in a confidential and anonymous manner.

Signature: ____ Date: __________________

***Youths cannot become members without signature from parent/guardian.**

Parent/Guardian signature: ______________________________ Date: ___________